REQUEST FOR CONTINUATION OF COVERAGE-SPECIAL RETIREMENT

Minnesota State Employee Group Insurance Program

TO BE COMPLETED BY THE EMPLOYER:

1. RETIREE INFORMATION

(a) CHECK ONE. The employee is retiring under the following retirement incentive: (Attach copy of incentive language in effect at time of employee's retirement.)

☐ Faculty ☐ Corrections ☐ DHS MOU
☐ Law Enforcement
☐ Other _____
☐ Contract ☐ Statute

(b)

Bargaining Unit	Anniversary Date
Years of Service in Current Pension Plan (if applicable)	
Pension Plan at Time of Retirement (if applicable)	

(c) Name (Last, First, Initial)	Employee ID No.	Birthdate	Age at Retirement
Department Name	Employee SSN	Department No.	
Spouse Name (if applicable)	Spouse SSN	Birthdate	

Last Date on Payroll	SEMA4 Retirement Date	Employer Paid Contribution to Continue Until:
_____ _____ _____	_____ _____ _____	_____ _____ _____
MO DAY YEAR	MO DAY YEAR	MO DAY YEAR

Human Resources Approval	Phone No.	Date

TO BE COMPLETED BY THE EMPLOYEE:

2. CONTINUATION OF HEALTH INSURANCE COVERAGE

	Self		Spouse	
Are you or your spouse eligible for benefits under Medicare?	☐ Yes	☐ No	☐ Yes	☐ No
Do you or your spouse have or applied for Medicare:				
Part A Hospitalization? Date: _____	☐ Yes	☐ No	☐ Yes	☐ No
Part B Medical? Date: _____	☐ Yes	☐ No	☐ Yes	☐ No

If you or your spouse are over 65, you will be required to submit Medicare information to your health plan. Call your plan for application forms.

I currently have coverage with the following health insurance plan: _____

Yes	**No**	
☐	☐	I wish to continue single health insurance coverage.
☐	☐	My spouse is under age 65 and wishes to continue health insurance coverage. (This would also include coverage for eligible dependent children.)
☐	☐	My spouse is age 65 or older and wishes to continue health insurance coverage.

3. CONTINUATION OF DENTAL INSURANCE COVERAGE

I currently have coverage with the following dental insurance plan: _____

Yes	**No**	
☐	☐	I wish to continue single dental insurance coverage.
☐	☐	I wish to continue family dental insurance coverage.

4. CONTINUATION OF GROUP LIFE INSURANCE COVERAGE (18 months) *See directions for optional life post-retirement benefits.

Yes	**No**	
☐	☐	I wish to continue my current basic/manager group life insurance for 18 months.
☐	☐	I wish to continue child life insurance.
☐	☐	I wish to continue employee optional life insurance.*
☐	☐	I wish to continue spouse optional life insurance.*

5. CONTINUATION OF MEDICAL/DENTAL EXPENSE ACCOUNT (MDEA) This is a pre-tax expense account administered by Eide Bailly.

Yes	**No**	
☐	☐	I wish to continue participation in the medical/dental expense account on a post-tax basis. Enrollment in the MDEA continues as long as monthly payments are made timely or until the end of the plan year, whichever occurs first.

Employee Signature:		Date:		
Home Address	City	State	Zip	Home Phone

AFTER COMPLETION, PLEASE SEND TO:
Minnesota Management & Budget, Employee Insurance Division, 400 Centennial Office Building, 658 Cedar Street, St. Paul, MN 55155

BILLING FOR LIFE INSURANCE

If you have optional employee life insurance, you may be eligible for a Post Retirement Life Benefit. Please complete the Post Retirement Benefit application (F43732). You will be billed by Minnesota Mutual Life for YOUR coverage until you reach the age of 65. If you continue to pay the premiums and have optional employee life in force for 5 years you will qualify for a reduced amount of insurance with no further premium payments. Please see the above mentioned form for further details.

If you wish to continue your Basic, Spouse and/or Child life, you will be billed by the Minnesota Management & Budget, Employee Insurance Division.

Minnesota Management & Budget
NOTICE OF COLLECTION OF PRIVATE DATA

Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we may request information (data) about you, your dependents and beneficiaries, how we will use it, who will see it, and your obligation to provide that information.

What information will we use?
We will use the information you provide us at this time, as well as information you have previously provided us about yourself, your dependent(s), and/or your beneficiary. If you provide any information about yourself or your dependent or beneficiary that is not necessary, we will not use it for any purpose.

SEMA4, the information system used to administer employee benefits, contains required information fields that may not be necessary for us to process your request. We do not need the gender or marital status for your beneficiary designation, so you may enter "unknown" in these fields. We only need your dependent's date of death to process a death benefit claim or to discontinue the dependent's coverage due to his or her death. Student status and disability status are needed only to determine eligibility for insurance continuation for your dependent. We need your dependent's social security number and birth to offer insurance continuation, process a death benefit and to comply with federal Medicare coordination laws.

Why we ask you for this information?
We ask for this information to process your request to add or change coverage for yourself, your dependent or a beneficiary. The requested information helps us to determine eligibility, to identify you and your dependents and beneficiaries, and to contact you or your dependents and beneficiaries. We use the information so that we can successfully administer SEGIP, including analyzing unidentifiable aggregate data to develop new programs and ensure current programs are effectively and efficiently meeting member needs. We may ask for information about you that we have already collected, including all or part of your social security number, in order to ensure we are matching you to the correct change request or other insurance benefit transaction.

Do you have to answer the questions we ask?
You are not legally required to provide any of the information requested.

What will happen if you do not answer the questions we ask?
If you do not answer these questions, the insurance benefit transaction you requested for you or your dependent or other insurance benefit transaction may be delayed or denied.

Who else may see this information about you and your dependents and beneficiaries?
We may give information about you and your dependents and beneficiaries to the insurance carrier you have chosen, SEGIP's representatives, vendors, and actuary, the Legislative Auditor, the Department of Health, any law enforcement agency or other agency with the legal authority to the information, and anyone authorized by a court order. In addition, the parents of a minor may see information on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that information. We can use or relates this information only as stated in this notice unless you give your written consent to authorize release of the information to another person/entity, or if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.

Request for Continuation of Coverage - –Special Retirement
Minnesota State Employees Group Insurance Program

Enrollment Instructions

All sections of this form must be completed entirely regardless of your continuation status.

Complete-the form and mail it to Minnesota Management & Budget (MMB) with a copy for your HR Representative

TO BE COMPLETED BY THE EMPLOYER

Section 1 – Retiree Information

a) **Check the appropriate box with the incentive employee is retiring under**
b) **Indicate the B/U, the anniversary date (equal to the date when employee started under the incentive he is retiring from), Pension Plan at the time of retirement and the number of years in the current pension plan.**
c) **Complete this section entirely including spouse information if applicable. Also indicate the last day on payroll, sema4 retirement date and the Employer contribution end date.**

TO BE COMPLETED BY THE EMPLOYEE

Section 2 – Continuation of Health Insurance Coverage

- Indicate if you and/or your spouse are eligible for Medicare
- Indicate if you and/or your spouse have Medicare now, or have applied for Medicare.
- Contact the health plan you will be a member of if over age 65 and request plan forms for Medicare.
- Indicate the health plan you are currently enrolled in. Please list your current plan even if you exercise your option to change plans.
- If changing plans, please complete a ***Basic Application for Insurance Coverage*** in addition to this continuation form. Attach a copy of the Basic Application to the continuation form before forwarding.
- Elect if you wish to continue health insurance for yourself. **Note: If you do not continue coverage, you cannot enroll at a future date.**
- Elect if you wish to continue coverage for your spouse. **Note: If your spouse elects not to continue coverage, he/she cannot enroll at a future date.**

Section 3 – Continuation for Dental Insurance Coverage

- **Note:** You do not have to continue health insurance to continue dental insurance.
- Indicate the dental plan you are currently enrolled in. Please list your current plan even if you exercise your option to change plans.
- If changing plans, please complete a ***Basic Application for Insurance Coverage*** in addition to this continuation form. Attach a copy of the Basic Application to the continuation form before forwarding.
- Elect if you wish to continue dental insurance for yourself. **Note: If you do not continue coverage, you cannot enroll at a future date.**
- Elect if you wish to continue coverage for your spouse. **Note: If your spouse elects not to continue coverage, he/she cannot enroll at a future date.**

Section 4 – Continuation of Group Life Insurance Coverage

- Indicate if you wish to continue your term group life insurance policy (basic or managerial) for 18 months. After that, you may convert to an individual life insurance policy
- Indicate if you and/or your spouse wish to continue the optional life insurance policy. **Note: You may be eligible for the post retirement paid-up life insurance benefit. Please contact your HR Representative to determine eligibility. Please complete the post retirement application form for you and/or your spouse whether or not you and/or your spouse wish to continue.**
- Please indicate if you wish to continue child term life insurance for 18 months if your children are still eligible. After that, child life may be converted to an individual policy

Section 5 – Continuation of Medical Dental Expense Account (MDEA)

- Please indicate if you wish to continue participation in the medical/dental expense account. **Note: By indicating yes this account will be continued on a post-tax basis. Also note that this account is separate from the Health Care Savings Plan (HCSP) or any HSA/HRA administered by MSRS or your pension plan.**

Please sign and date the bottom of the form. Also provide a home phone number

After signing the form, please return the completed form to your HR Representative in your agency.

Your HR Representative will make two copies of the form ***after*** he/she signs and dates the form. A copy of the form is sent to MMB. Additionally, your HR Representative will retain a copy for their records, and you will retain a copy of the form for your records.